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IN THIS ISSUE

AWARENESS · KNOWLEDGE · UNDERSTANDING
PREVENTION

THE ALCOHOLISM FOUNDATION OF ALBERTA

The Alcoholism Foundation of Alberta

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Telephone 424-1141

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LEARNING SOBRIETY

By A. W. FRASER

MANY alcoholics achieve and maintain periods of sobriety through treatment at hospitals and clinics. At the time the alcoholic terminates treatment, he understands the nature of his illness, realizes that moderate drinking for him is an impossibility and, as he is firm in his intentions not to drink again, feels he needs no further treatment. Several months later, he is drinking again.

What has happened to his conviction that he must never again take even a single drink? Or to his recognition that he is an alcoholic and does not, cannot, react to alcohol the way non-alcoholics do; that to drink at all inevitably means drinking to disastrous excess? In view of all his past bitter experiences, how could he ever again believe that he could control his drinking?

It may seem puzzling, but it really isn't. Some simple principles of a learning theory will enable us to understand why the alcoholic slips.

Principles of Learning Theory

1. *We retain knowledge, information, and attitudes which we use, and forget those we don't use.*
2. *Old imbedded learning is retained even though consciously used very little, while that recently acquired is lost quickly if not used.*
3. *If something gives us immediate pleasure, we remember it easily and will probably repeat it quickly and often, thus imbedding the learning firmly.*
4. *Things we learn easily are retained longer than those we learn with difficulty.*

For example, we do not forget, nor will we ever forget, simple addition and subtraction, because these were drilled into us as young children, and we use them every day. However, we soon forget high school algebra because it was 'newer' learning (learned later in life), and probaby not used after we left school. We will never forget our own or our brother's names, but how about someone we were introduced to last week, but haven't seen since? We can recite half a dozen nursery rhymes that we learned as children, but we forget a telephone number we memorized yesterday.

Old Learning

Let's relate these learning principles to the alcoholic and his drinking. What is the 'imbedded learning,' the information, attitudes, and beliefs about drinking and alcoholism, that will be well retained and used automatically to guide his behavior?

1. Society has taught him, since he was old enough to understand, that alcoholism is a sign of a shamefully weak character. And that anybody who amounts to anything can handle his liquor and will not get drunk if he doesn't want to.
2. His personal experience, first as a youngster by observation, then as an adult by participation over a good number of years, has taught him that alcohol gives immediate pleasure (even though this will now be followed by distress).

New Learning

In treatment the alcoholic gains new learning about drinking. This new learning is strong immediately after treatment, but will quickly be lost if he does not use it constantly for a long period. He learns that:

1. Alcoholism is an illness that develops in a cross-section of the population, regardless of will-power, strength of character, or personality.
2. He is alcoholic and, however adequate he may prove himself to be, he should never again use alcohol.

This is not only new learning, but also difficult learning—difficult learning which took years of bitter teaching to achieve. If the new learning is used frequently over a sufficiently long period, it will begin to imbed itself and will eventually become a firm part of the alcoholic's total personality. If it is not continually reinforced and kept strong by regular use, it will quickly be lost and the old learning will reassert itself. Further, the attitudes, beliefs, and behavior of the majority of the people around him will tend to reinforce and reactivate the original learning. Thus even after many years of sobriety, the recovered alcoholic should continue to reinforce the knowledge and conviction that he is alcoholic and should not drink at all.

AA as a Reinforcing Agent[1]

What can the newly recovering

alcoholic do to insure that his new understanding is not forgotten? The surest resource available to him for this purpose is Alcoholics Anonymous. It takes time and personal effort to benefit from the AA program, but there is nothing as important to the alcoholic as maintaining complete sobriety for the rest of his life. Therefore, he should not hesitate to put as much, if not more, time into insuring his sobriety as into insuring that he is successful at his job or in his family life. He may have to travel five, ten, or fifty miles to a meeting; he may have to visit several groups to find one he likes; he may feel for the first half dozen meetings that he can't 'buy' a lot of what he hears (he should remember that it took years of punishment and loss before he could 'buy' the fact that he was alcoholic); he may feel strange, uncomfortable, self-conscious for a while at AA meetings. Despite all this, he should not give up AA and try to get by on his own.

AA has helped hundreds of thousands of alcoholics to achieve and maintain sobriety; many of these had personal difficulties and problems similar to his own. AA is as much a standard prescription for the continuing recovery from alcoholism as is an iron tonic a standard prescription for continuing recovery from anemia. The person who won't take a prescribed and proven medicine because he doesn't immediately like the thought or the taste of it is being foolish. If he keeps on taking it, he will at least get used to it and may even get to like it. (After all, who enjoyed the taste of whisky at first—it took time and regular practice to develop a liking for that taste!)

The Advantages of Attending AA Meetings:

Regularly, once a week, sometimes more often, the alcoholic is investing time and effort into maintaining his sobriety by reviewing and refreshing his new learning about himself and his condition.

AA provides him with fellowship and a feeling of 'belonging.' He finds company and companionship with others who, like himself, are not 'drys,' but people who don't drink. When he starts the recovery process, most of the alcoholic's friends are really just drinking companions. Few of them will be around to provide him with company when he is no longer drinking. Further, his fellow AA members know from

Alcoholics Anonymous—Helpful Ally

Three papers in this issue of Progress — *Learning Sobriety, The Career of the Hospitalized Alcoholic,* and *How A Municipal Court Can Help the Alcoholic*— illustrate some of the ways in which Alcoholics Anonymous can serve as part of the community team in dealing with alcoholism.

their own experience the problems that face the recovering alcoholic. He will find acceptance and understanding in an AA group that he won't find in any other group. This doesn't mean that he is going to like every AA member that he meets. He may find that he dislikes a few, but this will apply to any community group that he joins.

AA provides activity, something to do to fill those long restless hours that used to be occupied by drinking. There are also Al-Anon meetings for the wife and social evenings for the couple.

By talking to other AA's and by listening to them, he learns that other people who seem to be good types, people he can respect and like, have had the same kind of embarrassing and shameful experiences, and gotten into the same difficulties, that he has. Also, he sees what happens when someone with a period of sobriety decides to try drinking again. This by itself is a powerful deterrent.

The Twelve Steps of Recovery in the AA Program

The AA program revolves around twelve steps of recovery. These are twelve guides to obtaining life-long sobriety and not only help the alcoholic maintain sobriety, but also affect positively his personal life. No 'don'ts' are involved, but instead twelve suggested 'do's.' No one can graduate from AA as having successfully completed the course, nor can anyone fully complete any one step except the first one.*

Twelfth Step Work*

Twelfth-stepping takes a number of forms, one of which is going out in response to a call for help from alcoholics who are still drinking but want to quit. The AA member who is just starting to do Twelfth Step Work is told that what he is doing is primarily for himself and only secondarily in the hope of helping someone else.

The recovering alcoholic tells his own story to the sick alcoholic, thereby reviewing and refreshing in his own mind the difficulties, the suffering, the awful hangovers, the feelings of despair and fear which once troubled him.

He sees before him a living example of the way he himself often used to be. He hears rationalizations about the causes of drinking and drunkenness similar to those he once used. He encounters the blindness (or denial) of the active alcoholic to the relationship between his drinking and his problems and to the necessity of giving up drinking completely.

This provides powerful reinforcement of his new learning.

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*Step One: We admitted we were powerless over alcohol—that our lives had become unmanageable. Perfection is not expected, although gradual improvement is hoped for and should be sought.

*Step Twelve: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practise these principles in all our affairs.

Sponsorship

After the AA member has learned a bit about the AA program and way of life, he may undertake sponsorship of a new member. This new member may be someone whom he has twelfth stepped, but it need not be. Good sponsorship entails much more continuing time and effort than does twelfth stepping and should not be undertaken lightly nor unless one is prepared to contribute a good deal toward helping a new member hang on to his sobriety.

Sponsorship is providing company, understanding, and encouragement to a struggling new member and it means, not only getting him to meetings, but staying with him during the meeting. It usually involves daily contact by phone and over cups of coffee for some time, and being available at all times. It means listening to his problems, his fears and frustrations and helping him to believe that they really will decrease as his sobriety lengthens. 'Sponsoring' activity, although involving a much greater effort to help others, is still primarily carried out for the sponsor's own good. He is learning to extend himself, to be concerned about others, to give up some of himself without expecting reward.

Sometimes the sponsor falls into the trap of expecting the reward of the new member's continuing gratitude and admiration, or of regarding the new member's success as a badge or tribute of his efficiency as a sponsor. If the new member displays ingratitude or lack of appreciation, or is unable to maintain sobriety, the sponsor may become angry, hostile, or punishing toward him, or may swing to the other extreme and become overanxious about or too protective of the new member. Either way the sponsor gets too stirred up, too personally involved and thus endangers his own sobriety. An alcoholic should be in AA for some time, long enough to absorb some of its basic teachings before attempting sponsorship work. However, providing good sponsorship to a new member is one of the most rewarding of AA activities.

ALCOHOLICS ANONYMOUS and the Alcoholism Foundation are not connected in any way. However, all Foundation patients are encouraged to join the AA group of their choice. The Foundation's view is that AA is the most effective long term therapy for the alcoholic. It provides fellowship, acceptance, and understanding and, if the alcoholic regularly attends AA meetings, his new learning about drinking and alcoholism is reinforced until, in time, it becomes an imbedded part of his pesonality.

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[1]This is an explanation of one way in which an association with AA is of benefit to the alcoholic. It is by no means a total explanation of the value of the AA program.

Drinking Habits of University of Alberta Students

By William Stocks

DURING the 1959-1960 term, I undertook a survey of the drinking behavior of University of Alberta students. I designed a brief questionnaire which was distributed to a hundred students at various campus locations. I selected places where students ordinarily gather, such as the cafeteria, study hall, coffee shop etc. The students were very interested in the survey, and only three who were asked refused to fill out a questionnaire.

The results were very similar to those found in studies of drinking by college students in the United States (1). They helped expose many of the stereotypes that have been built up about the drinking habits of university students. In many respects, the picture of the gay, carefree, heavy drinking student is more a matter of wishful thinking on the part of others than an accurate picture of reality.

It was found that 66% of the co-eds and 43% of the men students drink once a month or less. There was a fairly low percentage of total abstainers, comprising 9% of the men and 6% of the women. There was not a clear relation between year in college and extent of drinking. Fourth year students tended to drink the most, third year students drank the least, with first and second year students being somewhere in the middle. More drinking among Catholic students and those who expressed no religious preference was found than among Protestant or Jewish students. Those students with rural backgrounds tended to drink less than students who had come from cities or towns.

The type of beverage most frequently used by the students was also investigated. A marked difference between the habits of men and women students was found in this connection. The male students drank about equal quantities of beer and liquor while the women students, when they drank, tended to consume more liquor than beer. Wine consumption was very low among the students. Each person was also asked about the time of week when most drinking was done. Among both male and female students, the majority reported that drinking was done primarily on weekends and holidays. Each student was also asked whether he drank more at college than he did

when on vacation. Eight per cent of the men felt that they did more drinking at college, 50% said they did more drinking on vacation, and 42% reported that there was no difference. Basically the students felt that they did more drinking on vacation than they did in college so the effect of the campus life in producing the amount of drinking that is done can be questioned. (See Table I.)

Each student was also asked about his sources of alcohol. The answers are presented in Table II and show that the most frequent source is 'a friend'.

The students were asked several questions to determine their feelings and attitudes about the use of liquor. These results are summarized below and show a curious combination of attitudes. Almost 90% of the students approve of moderate social drinking, but also state that the abstainer does not suffer a loss in popularity. They also feel that they have no difficulty in refusing a drink. In fact, none of the co-eds reported any difficulty in this regard. (See Table III.)

Each person was also asked about his reasons for drinking. This was done with the aid of a check list. Each person was asked to check any of the reasons that was of some importance in his use of alcoholic beverage. The largest number of students felt that 'taste' was the main reason for drinking, followed by 'complying with custom' and 'being gay.' Conversely those respondents who were abstainers were asked why they did not drink. Over 75% of the abstainers gave religious reasons as the major considerations in not drinking. The second most popular reason was that the student did not like the taste or that liquor was detrimental to his health.

THESE RESULTS closely parallel the findings of studies of drinking patterns in American universities. The survey shows clearly that the stereotype of the college student as a heavy drinker is greatly exaggerated. The typical picture for men students is to drink two to four times a month and for co-eds to drink once a month or less.

REFERENCE

1. STRAUSS, R. and BACON, S. D., Drinking in College, New Haven, Yale University Press, 1953.

TABLE I.

Do you drink, on the average, more at college or more on vacation?

	At College	No Difference	On Vacation
Men	8%	42%	50%
Women	25%	50%	25%

TABLE II.

From whom do you most frequently get your drinks?

	Parents	Friends	Myself	Boot-legger	Lounges, Clubs
Men	21%	65%	12%	2%	—
Women	22%	76%	—	—	2%

TABLE III.

Do you personally approve of moderate social drinking?

	Yes	No	Not Sure
Men	88%	11%	1%
Women	91%	9%	—

Is it difficult for you to refuse a drink?

	Yes	No
Men	13%	87%
Women	—	100%

When Your Teen-ager Starts Drinking

by Garrett Oppenheim

'Boy, did we get smashed last night!'

How would you react if you overheard your teen-age son or daughter make this remark? Assuming you had no idea he or she touched liquor, you might well be shocked. A surgeon I know certainly was when he heard his 17-year-old boy say those very words to a school chum. The father—I'll call him Dr. Mesnard — promptly embarked on a rather high-toned lecture to his youngster.

'Dave,' he said, 'I'm a doctor. I know what alcohol can do to you. And my advice is: Leave it alone; it's a poison.' Then he went on to describe the cumulative effects of alcohol on the liver, brain, and stomach. He told how the taste for it insidiously became a craving and how the craving led straight to a derelict's end on Skid Row. Later, after he'd dismissed his son, and his wife had brought in the evening's pitcher of Martinis, he told her what had taken place. 'Let's throw these out and switch to ginger ale,' she suggested with mock gravity. The doctor laughed: 'Dave's too young to be drinking. Are we?'

And the matter ended there — until a few months later when Dr. Mesnard's hospital telephoned. His son and a friend were in the emergency room, both with multiple fractures. Dave had been to another teen drinking party—and this time he'd taken the car.

I've asked several physician-fathers how they've dealt with these problems. From what they've

told me, I've learned a number of things—among them why Dr. Mesnard's lecture to his son was a washout: (1) It didn't jibe with the example the doctor was setting at home. (2) It flew in the face of the known realities about alcohol, which, of course, does not necessarily damage the liver, brain, etc. (3) By stressing distant rather than immediate consequences, the lecture seemed to have no bearing on Dave's present life.

Some of the doctors I talked with offered the following positive suggestions for handling the teen-age drinking problem. There was practically unanimous agreement on the first of these.

1. Watch your drinking the way your children watch it.

'We all know the value of teaching by example,' remarks a Utah opthalmologist. 'But how many of us keep it in mind when we're serving cocktails to our friends? My older daughter brought this point home to me one night.

' 'Daddy,' she said, 'why can't I serve cocktails at MY party? They'll make everybody lively and friendly. You serve them to YOUR friends.'

'Fortunately, I had a come-back for her: 'Most of my friends can handle their liquor. Yours are still too young to learn how.' Even so, I've since kept a sharp eye on my own drinking behavior. And though I hope I'm still as hospitable as the next fellow, I never press another drink on the guest who's already had enough.'

A Virginia G.P. puts it this way: 'If you serve ANY liquor in your home, you're letting your kids know that you sanction the use of alcohol. So you'd better make sure they know the sanction isn't unlimited. That's why my wife and I never over-drink. If one of our guests does, we remind our children that drunken behavior is unattractive, unamusing, and unintelligent. My teen-agers have learned to think of alcohol as a dangerous blessing, like sharp knives and fire.'

2. Start your teen-age youngsters off with a drink at home.

Says a California internist: 'I'd rather teach my kids how to drink at home than have them experiment in secret. So I permit my daughter—she's 16—to have a glass of sherry with us once in a while. We don't make a big to-do about it, either. We don't want to glamorize the stuff.'

A Massachusetts surgeon agrees. 'I've taught my boys how to nurse one beer for a whole evening and resist the crowd's pressure. In my experience, it's the rigid, forbidding parent whose children drink for mixed-up reasons—and don't know when to say when.' That brings up a third question.

3. Tell teen-agers why people drink.

Show them liquor's good AND bad sides. A Chicago internist drew this picture for his 14-year-old

daughter: 'Drinking can make for good fellowship. It helps shy people shake off their inhibitions for a while. It gives temporary relief from worries. A drink before dinner increases the appetite. And one at bedtime can relieve tension and make a person sleepy. But that's just half the story. Here are a few items from the other half:

'Some silly people take to drinking because it makes them feel grown-up—or because they think their friends expect them to. Or if they're like your Uncle Fred before he got into Alcoholics Anonymous, they use liquor as a quick escape from themselves and their problems. They don't realize that it's a very dangerous — and really quite temporary — kind of escape.' The internist went on to quote this remark of Dr. Harold E. Himwich of the A.M.A. Committee on Alcoholism: 'The chief reason for drinking is to depress the brain and blunt the mind.'

4. Point up the dangers of alcohol in the here and now.

'Your teen-ager is simply not interested in the fact that drinking might lead him to alcoholism or a cirrhosis of the liver thirty years from now.' So says Prof. Raymond G. McCarthy, who has directed educational activities at the Yale Centre of Alcohol Studies. 'A much more important thing for him to think about is that drinking may deprive him of the family car on his next date.'

Many doctors find that tying in the facts of alcohol with unsafe driving makes sense to the young. Says a Nebraska pediatrician: 'I had to suspend my boy's driving privileges only once—for a month —to make him realize that drinking and driving don't mix.' A Rhode Island G.P. reports that his teen-ager became a drinkless driver once these facts were brought home to him: (a) Alcohol affects not only the drinker's reaction time but his judgment of his reaction time; and (b) black coffee may wake the drinker, but it won't sober him.

Accidents at the wheel aren't the only potential consequences of drinking. Some doctors remind their children that it's dangerous for a person whose alertness is dulled by alcohol even to cross the street on foot. Also, in his foggy state he's apt to make a fool of himself, alienate a friend, or wreck his scholastic career. A Pennsylvania psychiatrist tells his children: 'Until you've learned your own reaction to alcohol, the only way to avoid getting sick or acting badly is not to drink anywhere near what you think is your capacity.'

5. Show a film or hold group discussions on drinking problems.

An Ohio pediatrician did—and solved the drinking problem in his home for once and all. Dr. Wilgus (as I'll call him) didn't think he could effectively control his son's

drinking so long as the boy kept coming home with, 'Aw, Dad, all the fellows do it.' So the doctor invited 'all the fellows' to a meeting on the subject of drinking. His son's school gladly lent him a large classroom for the occasion. Wilgus Junior's friends and classmates packed it.

The doctor opened the proceedings with a short talk. Then he ran an educational cartoon on teen-age drinking, after which he held a question-and-answer period. The session made such an impression on the students that it's become an annual event. The doctor's son? He soon found there was more status in sharing his father's expertise than there was in having another one with the boys.

[Films and reading matter, suitable for such groups, are available from any of the Foundation's Centres.]

6. Get closer to your kids.

'Obviously,' says a Pennsylvania OBG man, 'The best way to keep your teen-ager out of trouble with alcohol, sex, or anything is to be a good, kind, loving father. And if anybody can show me how to be a successful obstetrician on less than sixty hours a week, I'll be a good, kind, loving father.'

You may see no way to cut down on your working hours, but it may still be possible to give your youngsters a little more of your time. A Maryland G.P., himself a recovered alcoholic, found time to see more of his son when the latter began to hit the bottle too hard. This doctor gave up his only hobby, golf, for activities his son enjoys: swimming in the summer, spectator sports in the winter, and once a year a two-week hunting trip. He began to make a bigger thing of Christmas, Thanksgiving, and birthday parties than he once did. And the doctor's wife, who formerly resented his long working hours, started telling her son, 'He works hard for his family.' It's taken two years of patience and continuous effort, but the boy has finally stopped drinking altogether and resumed his college career.

7. Get expert help.

When your own best endeavours have failed, it's time to look for professional guidance. A Vermont G.P. in desperation committed his drinking son to a sanatorium where intensive psychiatric help was available. But he took the step without turning his back on his son or censuring him. He knew he had a sick boy on his hands, and he responded as a physician.

What do these seven suggestions add up to? A Florida G.P. sums them up like this: 'I have just one way to deal with teen-age drinking in my family: I use every bit of the skill and training I have to maintain continuous good 'patient-relations' with my children.'

The Career of the Hospitalized Alcoholic

by R. W. Ramsay

THE FOLLOWING article deals with some observations of a group of alcoholics in a large Saskatchewan mental hospital. These observations may provide a useful framework for a more rigorous study, since little systematic research has been done on the career of the hospitalized alcoholic. The observations were collected over a several month period by the psychiatrist and the psychologist attached to the alcoholic unit.

The alcoholic in the mental hospital is usually a voluntary patient, but often is forced into entering the hospital either through circumstances, by a wife, friends, police, clergy, or family physician, or he may be committed for 60 days by two physicians or a magistrate. He is frequently at the stage of 'hitting bottom' when he arrives in hospital. Admission has been preceded by a drinking spree from which he finds himself afraid to sober up because of the hangover and the problems that are to be faced. The vicious circle of guilt feelings over his situation leads to the uncontrolled drinking that ends with some external force prevailing upon him to seek help from the Alcoholism Referral Centre. There he is screened and if he is felt to be in need of psychiatric treatment or has tried AA many times and failed, he is referred to the hospital.

If the alcoholic is severely intoxicated upon admission, he is first placed on a drying-out program on the medical ward. Otherwise he goes directly to the admission ward where he is put into the existing alcoholic group. He is usually accompanied by one of the counsellors from the Alcoholic Referral Centre who introduces him to the other alcoholic patients on the ward. Drinking circles are such that he knows one or two of the other patients in the group, or at least compares notes with them to find drinking companions of mutual acquaintance. In this way he soon begins to feel at home with the group. However, he is still appalled by the idea of spending two months in the hospital, and complains that this is too long, he won't know how to occupy his time, and he is not in such bad shape that it will require two months to set him right. Once he has decided to enter hospital for a 'cure,' he wants the 'cure' quickly. Even though he might have spent ten to twenty years getting himself into his present condition, two months to straighten out seems an eternity.

THE ALCOHOLIC unit on the admission ward is a ten-bed dormitory separated from the other areas of the hospital. The alcoholics use it as an island in a sea of un-

known mental patients, calling it the 'Happy Hours Country Club' with a notice to the effect that only members are allowed to enter. The dormitory contains a library of AA literature and paper-back novels, a record player lent by an ex-patient, records by Father John Doe, jokes and cartoons dealing with drinking, a large number of magazines (which are conspicuously absent from the rooms of the non-alcoholic patients), and pictures of scantily clad women. A locker contains a coffee pot, cups, and extra food, surreptitiously obtained from the kitchen and kept for evening snacks. The dormitory is for alcoholics alone, but they share the rest of the ward facilities with the other patients. They eat with the other patients in a common dining room, and a large day room and sun porch with T.V., pool table, and easy chairs, are open to all patients.

Each alcoholic knows at the outset that he will spend two months in the hospital and so can make arrangements about jobs and families. Since he is assured of discharge at a specific time, he is less reticent about discussing his problems and in being open in dealing with the staff. He does not have the feeling of many non-alcoholic patients that if he admits to symptoms or problems, he will be kept in hospital indefinitely.

The alcoholic would prefer to live on a separate ward or in a separate hospital, and has been very wary of entering a mental hospital. He tells his friends and relatives that, although he is in a mental hospital, he is still 'only an alcoholic.' The psychiatrist, on the other hand, believes that the unattractive surroundings will impress upon the alcoholic that he has really 'hit bottom.' He tells the alcoholic that not only does he have a mental problem, but is alcoholic too. The counsellor from the Alcoholism Referral Centre, himself a recovered alcoholic, tries to impress upon the alcoholics whom he escorts into the hospital that this period can be valuable and he keeps telling them, 'don't serve time in here, make time serve you.'

FOR HIS FIRST few days on the ward, the patient is not allowed grounds parole. He remains on the ward, resting most of the time, and is assigned light ward duties; during the first week this usually consists of dish washing. After the first week, he joins the rest of the group at carpentry. Group spirit is encouraged and he leaves the ward in the company of the other alcoholics and they take a common coffee break. He is free to make anything he wants at woodwork, and coffee tables, chests, and other household articles are taken from the hospital after discharge. He may even return to the hospital after discharge to finish a woodwork project which was not completed in time.

The structure of the group is constantly changing since new patients are admitted at the rate of one or

two a week. However, the alcoholic readily identifies himself with a particular generation of patients. Patients who enter in the last days of his stay on the ward or who leave during the first days of his admission are considered members of different generations. He begins talking about the way it was before he came and he makes invidious comparisons, such as, 'this group is more relaxed than the one that was here before. We have discussions now and are more democratic.'

Each generation usually has a 'goat,' a patient who becomes the butt for jokes or kidding. He acquires this label as soon as he enters the group and retains it for the full two month period. He seems to enjoy the role and uses it as a mark of status within the group. The group tends to close its ranks against the occasional patient who is more schizoid than alcoholic and force him out into the company of psychotic patients. They cannot throw him out of their dormitory completely, but he is given the bed nearest the door leading to the rest of the ward and he does not join in the evening group activities.

GROUP psychotherapy is scheduled four times a week and in addition each patient receives a number of individual therapy sessions with the psychiatrist. He is also encouraged to attend AA meetings, both downtown and at the hospital. If he deviates from accepted AA principals or rejects the therapy program, he is in danger of losing group support. This is no idle threat since the group represents a familiar island in a sea of approximately 1,500 'crazy' people. At times he resents the constant companionship and lack of privacy, but an internal group mechanism adjusts and subdues the pressures. If he starts going against the group, expressing resentment or causing trouble, he finds himself pushed out into the larger milieu of numerous psychotic patients with whom he feels nothing in common. This is usually sufficient to cause him to modify his behavior so that he can return to the group and once again feel the kinship of others with similar problems. He also recognizes that he has to be honest with himself and others, possibly for the first time in his life. He is usually willing to accept the fact that he has been a habitual liar. He has tried to bluff his way through various situations connected with drinking, and has often come to believe his own lies. When he joins the group, he meets others who are equally adept at this game and who can see through his alibis. He is also aware that he is trying to bluff the psychiatrist and the psychologist who have had experience with several generations of hospital alcoholics.

After the first few days on the ward, the alcoholic is given grounds parole and, at the discretion of the ward supervisor, can go downtown. On entry into the hospital, he resents the lack of freedom, but

after being in hospital for a few weeks, he begins to realize that he hasn't had any freedom for years. Because an occasional patient finds a downtown trip too much of a temptation, he is encouraged to travel with another patient; but this is not obligatory. After a month he can obtain weekend parole to stay with his family.

A constitution was drafted by the alcoholics on their own initiative and for their own guidance which states that the alcoholic patients are in hospital with a common purpose and a common goal. The constitution makes it explicit that the welfare of the group comes before personal welfare and that certain rules must be followed to protect the group. The first rule is that if a patient decides to drink, the group would prefer that he discharge himself before taking that drink. However, if a patient returns after drinking, the group will confine him to the security room until he is sober, and then decide, in conjunction with the staff, the action to be taken. Until a course of action has been agreed upon, the group takes turns staying with the offender. The constitution ends with the reminder that the members of the group cannot expect any undue privileges around the hospital ward.

AFTER LEAVING hospital at the end of the two-month period, the patient may return once or twice to visit the group or attend AA meetings, but these visits taper off as the group changes and he finds fewer acquaintances still in hospital. On a visit he may attest to the therapeutic value of the hospitalization. He may say that when he first arrived, he felt that the whole affair was a waste of time and he came only to satisfy a wife or relative or to prove to himself and others that he was going to try everything, even though he really didn't believe that his drinking habits could be changed. However, by the time of discharge he found that in spite of this aversion to change, or even the hope of some magical cure without any personal effort, he has been forced by the pressures of the group and AA and the therapy situation to take stock of himself.

Although the patient himself may change markedly during his stay in hospital he doesn't always recognize this; instead he attributes the change to the people around him. One patient at the end of his 60 day period told the psychiatrist, 'You sure have changed a lot since I have been here.'

Mr. R. W. Ramsay, a postgraduate student at the University of Alberta, worked as a counsellor at the Edmonton Clinic this summer. Additional material on alcoholics in this Saskatchewan mental hospital was published in a paper: JENSEN, Sven E. A treatment program for alcoholics in a mental hospital. Quart. J. Stud. Alc. 23: 315-320, 1962.

I SAVED MY HUSBAND FROM ALCOHOLISM

By an Anonymous Wife

as told to Jim Poling

TODAY, at least one out of every 20 families in North America is affected by the problem of alcoholism. In their efforts to understand and deal with this alarming situation, psychiatrists and experts on alcoholism have recently dicovered a startling fact: Most wives of problem drinkers actually do their husbands more harm than good in their well-meant attempts to help them stop drinking. In fact, they often drive their husbands to drink more rather than less.

Because of this, we have a new approach to the problem of the drinking husband: First treat his wife. Psychiatrists help her to get rid of her unreasoning emotional reactions and give her a fresh insight into the problem. Once a wife knows how to act toward an alcoholic husband, the job of helping him becomes easier. In effect, she opens the door for him.

My own story is a perfect example and I tell it only in the hope that it will show other alcoholics' wives the importance of seeking professional guidance. If my story

helps even one despairing wife save her marriage, I'll be amply rewarded.

'Home Treatment' Never Works

It took me 11 years of living with an alcoholic husband to find out that everything I was doing to try and help him was wrong. I was giving Steve the 'Home Treatment,' which is the ironical name psychiatrists and experts on alcoholism have given the methods almost universally used by wives who are 'trying to bring their husbands to their senses.' These methods never work.

The Home Treatment is a compound of futile talk, weeping, and pleading. I thought I was talking to Steve with 'sweet reasonableness,' but I hate to think of the number of bitter rows that grew out of these so-called calm discussions.

Then I pounded him with meaningless emotional appeals: Don't you love me? Think of the children! Have you no self-respect? and so on, far into the night.

I tried coaxing too, of course, and discovered that when you promise to do anything if your husband will give up drinking, you end up sobbing. So I turned to threats. I threatened to leave Steve on an average of about once a month.

And I did leave him a few times. But, because I loved him, I always returned as soon as he solemnly promised to stay sober. Nothing I did had any lasting effect on him. I poured his liquor down the sink, only to have him stalk angrily out for more. I persuaded our friends —as long as we had them—not to serve liquor to him at parties.

To spare him 'unnecessary worries' I took over as head of the family; managing the checking account when there was one, fighting off the creditors, even making the minor repairs around the house. When he suffered incapacitating hangovers, I called his office and lied to cover up for him. And still he drank.

It never once occurred to me that from Steve's point of view I was a nagging, preaching wife who went on and on at him until he had to go back to the bottle in self-defense. I was aggravating the very condition I was trying to cure.

By the end of 1957 I was desperate. Things were much worse than they'd been when Steve began drinking, after his return from World War II. We were deeply in debt and his accountant's job was in jeopardy. What's worse, my nine-year-old Doug was so afraid of his father that he'd run sobbing from the house the moment Steve raised his voice.

My 15-year-old Ann was different. When her father went into a drunken rage, she'd grab a poker or an iron skillet and lock herself in her room crying out, 'If you dare touch me, I'll brain you.' Both youngsters were failing in school, and they were both lonely, withdrawn creatures who'd never brought a playmate into the house.

The Turning Point

I was a nervous wreck, living on coffee and cigarettes and bursting into hysterical tears on the slightest provocation. For the first time, I began to think seriously of a divorce.

Then came a turning point. On Christmas Eve, 1957, Steve didn't come home. The children and I went through the pitiful travesty of opening the presents under our small tree without him. He finally returned the morning of the 27th, with four bottles cradled in his arms, 14 cents left out of two weeks' salary and his year-end bonus, and in such dreadful shape I had to have him hospitalized immediately. However, when he came out of the hospital he was so remorseful that, for once, he was willing to do anything I asked of him.

I arranged for him to see a psychiatrist. This lasted three months. Then Steve came home drunk one night, yelling, 'I've fired the head-doctor. I'm sick of his damn prying questions.' I'll never forget the moment. I was peeling potatoes, and suddenly I thought, 'All you've got to do is take this knife and stab him. Just a few stabs and it would all be over.'

Somehow I managed to control myself. And the next morning I called the psychiatrist and asked his advice. He gave me a telephone number to call. 'It's our local Alcoholism Information Centre,' he said. 'Maybe they can help you. They did—they saved my marriage.

A pamphlet 'Help for the Alcoholic —What the Family Can Do' is available from the Foundation's centres.

My Problems Came First

At the Centre I was turned over to a psychiatrist case-worker, who was to be my counsellor. I gave her the history of Steve's case, and told her he had once tried Alcoholics Anonymous, which had helped so many, only to abandon it in much the same manner he'd just given up psychiatry. Was he beyond aid? She said no alcoholic is beyond aid, but that we were getting ahead of ourselves. Before worrying about Steve, we had to consider my problems. Until I solved them there was little chance of Steve's ever responding to treatment.

To begin with, I had to realize that I myself was sick. Over the years, the strains and tensions set up by Steve's drinking had made me an emotionally disturbed, overwrought woman who was no longer capable of thinking or acting realistically. Until my emotional balance was restored, it was impossible to help Steve.

Furthermore, I had a block, perhaps the most important single factor in preventing me from giving him the help he needed. I was only giving lip-service to the idea that Steve's compulsive drinking was a disease, while emotionally rejecting it. I treated him as if he were drinking deliberately and wilfully. As a result of my efforts

were so wide of the mark that, if we thought of Steve's illness in terms of a sore toe, I could be accused of trying to step on it.

I had to learn to tread lightly in the region of his toe, for it was a very painful one. He was suffering from feelings of guilt, remorse, and self-hate incomprehensible to a non-alcoholic. Alcohol was the crutch Steve used to support a crippled ego. And anyone who tried to take it from him would be met with grim defiance.

That was why my Home Treatment hadn't worked. I had reminded him of his failures, made him hate himself even more. I had increased his sense of guilt and whittled away at his self-esteem. When I'd taken over his role as head of the house, I'd undercut his manhood and his self-confidence at a time when they badly needed building up.

'The Family Illness'

At this point, Steve and I hardly ever spoke to each other except in bitterness. My son was living in fear of his father, while my daughter seemed to take a cruel delight in calling her dad a 'no-good bum.' Well, perhaps then I could understand why alcoholism is called the 'Family Illness.' Steve's sickness had made us all emotionally unhealthy. Our home atmosphere was enough to drive any man to drink, let alone, an alcoholic. How could I expect Steve to come home sober to face a family that met him with fear, disgust, shame, even hatred?

He would continue to turn to his bottle as long as he had to breathe such an atmosphere. It was his only defense. Now it was up to me to create a new climate in my home, one that would make Steve feel wanted rather than rejected. Everything hinged on this. I had to stop driving Steve to drink, had to begin giving him support and understanding. He'd never seek help, much less respond to treatment, until he had been given a reason to want to stop drinking. And there was no better way to do this than to convince him that there was still a place for him in the family circle.

It wasn't going to be easy, the case worker warned me. It meant an almost complete change in my behavior and my attitudes. She thought I should come to her regularly for counselling, and also enroll in the weekly group meetings the Centre held for wives of alcoholics. I agreed immediately.

In the long weeks that followed, under the gentle guidance of my counsellor and with the sometimes sharp-tongued advice, support, and criticism of the other wives in the group, I changed. I could think clearly for the first time in years, and I even began to react like a normal human being. What's more, once I understood something about the fears that were driving Steve to drink, it was possible for me to feel in my heart that he was sick.

This made a world of difference, for it drained me of all my hurt and anger. Steve's continued drinking was still a trial to bear, but it

was a trial of love, not bitter injustice. I had nothing to hold against him any more.

The Children Learned Fast

So I slowly acquired compassion and understanding, with the inevitable result that my attitudes toward Steve and his drinking softened. And the change in me brought on changes at home.

Doug and Ann were the first to reflect them. Often before I'd explained to them that their father was a sick man. But because I'd never fully believed in myself, I'd never convinced them. Now that I was sincere, I succeeded.

With Steve, I stopped treating him like a delinquent child. I did everything I could to restore his dignity as head of the house. I made him make decisions. I stopped 'mothering' him excessively. And I asked for his help whenever possible, trying to show him that I needed him—as I did, or I'd have left him long since.

I tried to draw him nearer to me. This posed unexpected problems. For example, I hadn't given Steve a homecoming kiss in years, since the night he angrily accused me of kissing him just to check up on his breath. What was I to do now? I finally got up the courage to try, thankfully on a night he came home sober. When Steve recovered from his shock he said, almost humbly, 'Thanks. I've missed that.'

Don't talk about drinking

Above all, I never mentioned his drinking unless he brought the subject up first. And when he did bring it up, I tried my best to make him see that I'd come to understand what he was going through, and tried desperately to pass on to him something of what I'd learned about alcoholism.

In short, I tried with all my heart to put into practice the principles I'd learned at the Centre. And eventually they had a therapeutic effect on Steve, just as I'd been told they would.

Half jokingly, my counsellor had offered to bet me that Steve would show an interest in the Centre within six months of the time I succeeded in creating a healthy atmosphere at home. Well, I went to the Centre on May 7, 1958. Five months later, Steve sat on the edge of his bed one morning, after a particularly bad night, and said to me very quietly, 'You know, you haven't nagged me for months. Don't think I haven't appreciated it. You've been wonderful. And here I go and pull something like last night on you. I'm beginning to think I'm nuts. Maybe I should talk to that woman you've been seeing. What's her number?'

I'd finally done my job—with outside help. And that, I think, is the lesson to be drawn from my story. To handle an alcoholic husband, you must have expert help and

Wives, husbands, and other family members of alcoholics are encouraged to seek help from the Foundation's treatment and information centres.

guidance. Without it—ignorant of the true nature of alcoholism, ill-advised by friends and relatives, and too emotionally upset yourself to make sense—you inevitably turn to the Home Treatment. And it never, never works.

When Steve went to the Centre he was referred to a doctor who placed him on Antabuse, under close medical supervision. This is a drug that makes you violently ill if you take a drink while it's in your system. The idea was to make it impossible for Steve to drink for a while, so he could clear his head of alcohol. Once he'd begun to think soberly, my counsellor went to work and, praise be, managed to get through to him. She suggested he try group therapy. He agreed, somewhat sceptically. And to his surprise and delight, it worked. Since then he's been sober, for two glorious years.

HOW DO WE stand today? Steve's cure has changed everything. We're almost out of debt. Among other things, Ann is teaching her father to cha-cha. This past summer, Steve took Doug and three of his pals camping.

I have confidence in the future. For if Steve should ever slip, I think I'll know how to handle the situation. Thanks to the Centre, I've learned my lesson. Love is an alcoholic's greatest need.

$375,000 Donation to Centre of Alcoholic Studies

Gifts totalling $375,000, about half the cost of constructing and furnishing a building for the Rutgers Center of Alcohol Studies, have been received from the Christopher D. Smithers Foundation, Inc., and its president, R. Brinkley Smithers of New York.

Mr. Smithers said that the gifts were made 'with the earnest hope and expectation that by creating the first adequate facility under one roof for the study of alcohol and alcohol related problems, the causes which bring about the complex disease known as alcoholism can be discovered.'

The Smithers Foundation, set up in 1952, works through other organizations and also initiates its own projects directed towards the prevention, diagnosis, treatment, and control of alcoholism, cancer and other diseases.

The Center of Alcohol Studies, which transferred from Yale University to New Jersey's state university early this year, operates a four-pronged program of research, education, publication, and documentation. It attempts to develop greater understanding of man and his society through analysis of alcoholic beverages and their use.

How A Municipal Court Helps Alcoholics

A large proportion of the people who appear in the municipal courts on any given day are there because they have been arrested for intoxication or for some offense growing directly out of intoxication. The same people tend to appear repeatedly. An increasing number of judges and other officers of these courts have been seeking ways to use the court to help the so-called chronic police-case inebriate. In the District of Columbia the Municipal Court, through its probation department, has developed a program that has achieved considerable success, as described by E. W. Soden.

In 1946, members of Alcoholics Anonymous began to meet informally once a week with men on probation who came to the courthouse for the required weekly report to a probation officer. These volunteers explained the AA program and discussed the probationers' problems with them. So effective was this experience that in September, 1958 the program was expanded and named the Municipal Court Alcholic Rehabilitation Unit.

When a man charged with intoxication is found guilty, a probation officer on the staff of the Rehabilitation Unit hands the judge a copy of the defendant's record and makes a quick evaluation of his potential. If there are indications that he might profit from the program, he is interviewed at once by another officer of the Unit who talks to the man not as one sitting in judgement on him, but from the standpoint of trying to find out whether he has 'a desire to help himself and to do something about his drinking.' If he appears to be suitable, it is explained to him that he will have to return to jail for a few days to sober up and get into a physical and mental condition such that he may understand what the court program will offer him. The defendant is then taken back before the court and his case is 'continued' for a number of days.

The next step comes after the defendant has 'dried out.' Every morning, Tuesday through Friday, one of the probation officers goes to the cell-block and takes those men who are ready to a courtroom assigned for the use of the program, a comfortable room that provides 'an official yet relaxed environment.' Present are two of the probation officers who understand the men's problem from personal experience and three to five members of AA. All these men 'speak the language' of the defendants. The program and function of AA is explained in brief talks, the details of the court program are outlined, and the men are offered a

chance to try it. There is no coercion. Each man has full freedom to decide for or against accepting the program. To those who accept it, only one request is made: the investment of an hour's time each week to attend a meeting about AA held in a courtroom of the Municipal Court. It is stressed that the Alcoholic Rehabilitation Unit is not a group of Alcoholics Anonymous, but that it employs the AA principles and philosophy. The meetings, conducted by men who have themselves achieved sobriety through the court program, are open to wives, parents, and relatives, many of whom attend. The cost of coffee service is met by the men themselves.

A man who accepts the program at the end of the briefing session then appears in court and the probation officer recommends that he be released on personal bond. This is, in effect, a suspended sentence. After his court appearance, each man is interviewed individually by probation officers who obtain personal data for the purposes of the record and who arrange for temporary food and lodging if necessary, employment and job counselling. The office of the Unit is open every afternoon to allow the men to discuss personal problems. Referrals may be made to community agencies for clothing, medical care and other needs.

What has been the success of this program? Out of 32,889 people who appeared before the court in an 18-month period, 8,303 were screened by the Unit and 4,440 or 36.4 per cent were released to it on probation. Of these men, 2,438 did not reappear in court for at least 6 months—the period taken as a 'measuring stick of success.'

Besides the saving to the community of the costs of jail confinement for these men, there are economies 'that derive from gainful and productive employment, increased earning capacity, payment of taxes, and financial savings to welfare agencies which would have had to care for those men and their families while they are unemployed or serving a jail sentence.' And far more significant, Soden concludes, are the intangible benefits 'from salvaging a human being and preserving his family and his home.'

REFERENCE
SODEN, E. W. How a municipal court helps alcoholics. Fed. Probation 24 (No. 3): 45-48, 1960.

NOTES ON WARSAW

In scarcely nine years of operation, The Alcoholism Foundation of Alberta has achieved international recognition. This fact was amply demonstrated in the reception accorded to the Executive Director, J. George Strachan, by the sponsors and delegates of the International Union Against Alcoholism in Warsaw, Poland, during their June 11 - 22 meetings.

Mr. Strachan left Edmonton May 16th, and, in the course of a crowded two-month itinerary, covered a goodly number of North America's, Britain's, and Western Europe's leading alcoholism treatment and programming centres. In Warsaw, he delivered a comprehensive and detailed paper on 'The Administration of a Programme Against Alcoholism,' with special emphasis on the role and aims of Education, in terms of its development, application, and its empirical evaluation by the Foundation.

Mr. Strachan first presented a total view of the problem of alcoholism against the background of its proliferous social and economic involvements. His paper then outlined the management of a total programme and the various types of services implemented within its scope. The relationship of an alcoholism programme to other available community facilities and resources, as well as to other vocationally and avocationally interested groups in the community, were explained. This was followed by a brief outline of the concerns of an alcoholism programme with other interested groups, such as professional, recovering alcoholic, abstaining, and temperance.

Summing up, Mr. Strachan concluded: 'Programming against alcoholism is no longer a questionable thing; rather, it is going on in many segments of the public health field. Sound administration will make this a lasting programme and not a momentary public gesture. As dedicated and experienced workers share their skills and pool their services, so must the administration ensure that their efforts are properly coordinated to make a meaningful contribution in a total treatment effort against the illness alcoholism.'

Mr. Strachan travelled on a grant from, and with, Mr. R. Brinkley Smithers, President of the Christopher D. Smithers Foundation of New York City. He expressed his appreciation of the Polish Health Ministry's courtesy in making available to him the exceptional opportunities he had for visiting and observing various treatment clinics there.

'I cannot help but feel,' Mr. Strachan commented, 'that this was in large part a gesture of appreciation and friendliness to me *as a Canadian.* The Polish people had, in many ways throughout our stay, expressed a warm, full, and highly interested cultural and scientific sympathy with Canada.'

Held in Warsaw's impressive Palace of Culture and Science, the meetings of the International Union Against Alcoholism were attended by over 200 delegates from 22 countries.

'My overall impression is that there was generally unanimity among the delegates as to the fact that alcoholism contributes to the proliferation of a multitude of other social and economic problems more seriously and more frequently than is realized by the public at large in most countries. It was also amply evident that education, especially in terms of prevention, needs a great deal more emphasis, everywhere.'

Asked about his observations regarding the European programmes, Mr. Strachan said, 'Some of them have done a great deal of advanced research, both physiological and psychological. I also found reason to conclude that, in some countries, the problem of alcoholism may be more serious than is generally avowed because of social and political circumstances. In many countries, too, heavy drinking, because of its obvious economic aspects, is largely confined to the relatively small upper income groups.'

'It was a valuable experience and a wonderful trip,' Mr. Strachan concluded. 'Our doors on the world threshold opened a little wider and I'm sure that all concerned benefitted greatly. And though we can be justifiably proud of our work and reputation, we do well realize how much still remains to be done.'

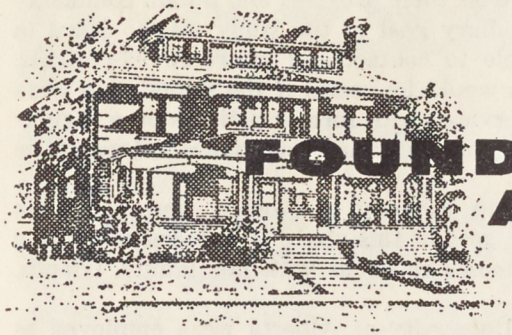
Mr. Strachan paused, and added: 'It would be difficult indeed to improve on the wise observation of Mr. R. Brinkley Smithers, who closed his Warsaw presentation with the following statements:

'All these international get-togethers on alcoholism are part of an overall effort in the field of public health which might be termed *World Peace Through World Health.*'

and

'Health presents a much stronger message of humanity than anything else, and is understood immediately by the great masses of people everywhere. It transcends propaganda or any ulterior motive and aims at the betterment of humanity through combating sickness . . . .'

J. Motyl
Associate Editor



FOUNDATION ACTIVITIES

New Staff

Mr. A. D. Dick, Counsellor, and Mrs. M. S. Bahrey, Nurse, have joined the Edmonton Clinic. Mr. James H. MacInerney has joined the Educational Services staff in Edmonton.

Foundation Joins Calgary's United Fund

The Foundation has been accepted as a participating agency in the United Fund of Calgary and District. Calgary's United Fund campaign was conducted from September 8th to October 1st.

The Foundation joined the United Community Fund of Greater Edmonton in September 1960.

TREATMENT ACTIVITIES —

April - June 1962

During the second quarter of 1962, intake remained high at the Edmonton and Calgary clinics. At the Edmonton clinic, 122 new and reactivated patients were seen and at Calgary 81 new and reactivated patients. 2,000 counselling interviews were held. The evening therapy groups were well attended. The day groups for beginning patients were continued in Edmonton and are planned for Calgary in the Fall.

The Clinics at Lethbridge, Medicine Hat, Grande Prairie, and Westlock continued to be used by these communities. Counsellors conducting these clinics maintained full interview schedules.

RESEARCH ACTIVITIES

Summer, 1962

This was a particularly active period for the Research Department with several new studies begun and old ones completed.

Mrs. Aldridge finished her interviews for a study of patients' reaction to treatment. Individual interviews were scheduled with 36

former Foundation patients to assess their progress and obtain comments on the services offered. A subsidiary goal of the study was to learn to what extent it would be possible to contact and interview ex-patients. It was felt that this information would be useful if the Foundation were to begin the use of check-up interviews with former patients on a regular basis. The material in this survey is under analysis and a full report is in preparation.

Mrs. Hochachka has begun a study of women who had been patients at the Foundation. The goal of this study is to learn something of how alcoholism affects a woman's relations with her family, friends, and community.

Several students at the University of Alberta were employed as Research Assistants for the summer months. Mr. O. Porayko, a medical student, in addition to helping the treatment staff, has been involved in assessing alcohol problems at the Charles Camsell Indian Hospital. He has interviewed a number of patients who were thought to have drinking problems and is currently preparing a report describing the findings. Mr. Porayko, in addition to his interviews at Camsell Hospital, attempted to learn something about the non-white patients who have come to the Foundation during the last five years. To this end he undertook a small sociological study of the social characteristics of non-white patients. Mr. J. Whyte, also a student of the University of Alberta, is currently working with Dr. Sommer in a study of the isolated drinker in Edmonton.

Mr. Wilby in addition to helping Mrs. Aldridge with her study is presently drawing up plans for an investigation of drinking patterns in a small community. Dr. Sommer, assisted by Mr. R. Ramsay, has been studying the self-concept of alcoholic patients in order that comparisons may be made between the manner in which out-patients and hospitalized alcoholics view themselves as 'sick' persons.

Professor John Hostetler of the University of Alberta, Sociology Department has submitted his report on the Use of Alcohol and Drinking Patterns among the Hutterites in Alberta.

Other activities of the Research Department include the construction of a questionnaire regarding alcohol use and alcoholism to be given to medical students and graduate students at the University of Alberta; assisting the Library and Publications staff in a survey of reader opinion about Progress; and development of a brief questionnaire to evaluate workshops on alcoholism.

Dr. Sommer also completed his report, written jointly with Mr. Dewar of Saskatoon, describing a 'before and after' study of alcohol consumption in a small Saskatchewan Community. A lengthy report outlining the findings and recommendations has been submitted to the Government of Saskatchewan.

Mr. Ramsay and Dr. Sommer completed a paper describing the use of the Hallucinogenic Drug, LSD25 with alcoholic patients. The experimental work had been done at the Saskatchewan Hospital, Weyburn.

EDUCATION ACTIVITIES

Summer 1962

This was a period of versatile effort for the Foundation's education division. With the relaxation of scheduled lecturing commitments for the holiday months, our staff found time to broaden their activities considerably. In addition to a regular series of lectures to student nurses and nursing aides, considerable time was given to writing informational articles, to fall and winter schedules and planning, to industrial programming and general public and corporate liaison work.

The Edmonton administrative centre's lecture room facilities were made available to student nurses from the University Hospital's Out-patient Clinic. The Foundation provided a two-month series of weekly lectures and film showings as part of the Out-patient training curriculum. Several groups of nursing aides also attended instructional lectures at the Edmonton centre.

For the first time, the Foundation this year took part in the United Community Fund display activities at the Edmonton Exhibition. Two Foundation staff members manned the booth during a specific time allocation, distributed literature and answered queries. Some valuable observations were made for an improved, more effective display next year.

A number of articles were written and compiled to produce a special booklet on the Alcoholism Foundation of Alberta for Family Welfare study groups. This booklet was requested by the Edmonton study group on Family Welfare, and it presents, in fairly comprehensive detail, the work of the various treatment, education and research personnel involved in the Foundation's program.

Staff members from the Foundation's education division visited the RCAF station at Cold Lake, early in August. Cooperation and interest of the commanding officer, and of his senior staff, resulted in a gratifying amount of preliminary groundwork in preparation of an effective alcoholism referral and counselling program at the station.

The implementation of an industrial alcoholism referral and treatment program in one of Alberta's major public utilities got under way—first with a series of generally informative articles in the corporation's house organ, later with a series of planned orientation and instructional lectures to executive and supervisory personnel. The essen-

tial objective here is to allow everyone concerned to learn about alcoholism, about the necessary program for dealing with it, and to impart special knowledge and understanding to the personnel who will come into direct and regular contact with the employees who may need help.

In September, the regular medical and nursing staff lectures at the Aberhart Memorial Sanatorium were resumed after the holiday recess, and a similar program was instituted at the Baker Memorial Sanatorium in Calgary.

The Edmonton Youth Advisory Committee resumed its regular liaison meetings with Foundation Educational Services staff, and a promising schedule of activities has been outlined for the next several months. A Speakers' Bureau has been formed for the filling of speaking engagements with church and other youth organizations. Six of the committee members volunteered to undertake intensive study under Foundation guidance in order to qualify for speaking assignments.

Calgary staff spoke to a number of church groups, in addition to a film-showing at the Foothills AA group in the Calgary Provincial Gaol, and a regular seminar at the Foundation for student nurses from the Calgary General and Holy Cross hospitals.

The Foundation has entered into talks with executives of the Calgary branch of a large processing company, with a view to setting up a company policy and plan for rehabilitating alcoholic employees.

In Red Deer, Mrs. H. Irvine addressed the staff doctors and associate medical staff of the Red Deer Municipal Hospital. This was on the request of the doctors, who not only wished to meet Mrs. Irvine, but to learn more of the Foundation's aims and activities as they are being conducted in Red Deer.

Foundation staff members attended the Group Process Institute in Banff, and the Group Dynamics Institute at the Ponoka Mental Hospital, during September.

Two members of the Foundation's educational services, C. Robert Dickey from Edmonton, and Gordon Wemp from Calgary, attended the National Alcoholism Council's summer school on 'Alcoholism and Community Action' at Columbia University in New York. This course was specially prepared for study of factors that contribute to success in organizing local communities for active participation in the whole alcoholism program, as part of a total public health team.

N.A.A.A.P. ANNUAL MEETING

The 13th annual meeting of the North American Association of Alcoholism Programs will be held in Bismarck, North Dakota on October 7 - 11, 1962. The theme of the meeting will be 'Alcoholism Programs, Controversial Concepts and Attitudes.'

Mr. J. George Strachan, Executive Director, and Mr. Allon W. Fraser, Director of Treatment will attend the meeting.

THE ALCOHOLISM FOUNDATION OF ALBERTA
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